SECTION 6
COST SHARING – COPAY – COINSURANCE

Providers of service must charge and collect the cost sharing, copay or coinsurance amount from patients, unless otherwise exempt. It is the responsibility of the patient to pay the required amount due. Providers may not deny or reduce services to patients, otherwise eligible for benefits, solely on the basis of the patient's inability to pay. Whether or not the patient is able to pay the required amount at the time the service is rendered, the amount is a legal debt and is due and payable to the provider of service.

Cost Sharing

The following cost sharing amounts are applied to *dental* services; CPT or surgical procedures are not subject to cost sharing. The amount of cost sharing to be collected from the patient is based on the Missouri Medicaid Maximum Allowed Amount *per* procedure.

Medicaid Maximum Allowable	Cost Sharing
$10.99 or less	$ .50
$11.00 - $25.99	$ 1.00
$26.00 - $50.99	$ 2.00
$51.00 or more	$ 3.00

Exemptions to Cost Sharing & Coinsurance

- Patients age 17 and under
- Foster Care children up to 21 years of age, ME codes 07 and 08
- Hospice patients
- Patients residing in skilled nursing facilities
- Patients residing in residential care facilities or adult boarding homes with ME codes 14, 15, or 16
- MC+ health care plan enrollees for services provided by the health plan
- When copay is charged for patients with ME codes 74, 75 and 76
- When coinsurance is charged for dentures

Copay

Patients with ME code 74 must pay a $5.00 copay for identified services; patients with ME codes 75 and 76 must pay a $10.00 copay. These copay amounts apply whether the patient receives services on a fee-for-service basis or is enrolled in a health plan. The following services require copay:

99201	99211	D0120	D9310
99202	99212	D0140	D9430
99203	99213	D0150	D9440
99204	99214	D0160	
99205	99215	D0170	

Denture Coinsurance

The coinsurance amount applies to each interim, partial and full denture unless the patient meets one of the above exemptions. The amount collected from the patient is 5% of the lesser of Medicaid's maximum allowable amount or the provider's billed charge.

Procedure Code	Medicaid Maximum Allowable
D5110	$ 357.00
D5120	$ 355.00
D5130	$ 361.00
D5140	$ 360.00
D5211	$ 272.00
D5212	$ 276.00
D5213	$ 385.00
D5214	$ 386.00
D5820	$ 286.00
D5821	$ 286.00
D5860	$ 457.50
D5861	$ 457.00

NOTE: Procedure codes D5860 and D5861 require an approved prior authorization and are restricted to patients under the age of 21.